CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR CHEMICAL DEPENDENCY PROFESSIONAL LICENSURE
INSTRUCTION SHEET

General Information

Please read all instructions carefully before completing and submitting your application. Failing to follow instructions may delay your licensure. All auxiliary forms you need are included in this packet.

If your application is not complete within six months of filing, it may be considered abandoned and discarded.

- If you hold a *current* Chemical Dependency Professional license in another jurisdiction (state, the District of Columbia or U.S. territory), follow the instructions for applying by reciprocity.
- If you do ***not*** hold a current Chemical Dependency Professional license in another jurisdiction ***and*** you currently certified by the Delaware Certification Board Inc. (DCB), National (NAADAC) or other national mental health specialty certifying organization, follow the instructions for applying by certification.

Requirements for *All* Applications

☐ Submit completed, signed and notarized *Application for Chemical Dependency Professional Licensure*.
- Applications that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose the processing fee by check or money order made payable to the "State of Delaware."
- Applications not accompanied by the required fee will be rejected.

☐ Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
- You must meet this requirement *even if* you recently had a criminal background check done for some other reason.

☐ Arrange for the Board office to receive a verification of licensure from each jurisdiction (state, U.S. territory, District of Columbia) where you now hold, or have *ever* held, a license to practice as a mental health professional.
- You may use the *Verification of Licensure* form enclosed with this packet to request the verification.

☐ If you are certified by the Delaware Certification Board Inc. (DCB), arrange for the Board office to receive a *Delaware Certification Board, Inc., Certification* form. If you are certified by NAADAC, arrange for the Board office to receive a *NAADAC Certification* form. The forms must be sent directly from the organization to the Board office. Follow the instructions on the forms.
- If you are certified by both organizations, certification forms from both are required.
- If certified by NAADAC, you must be certified as either a National Certified Addictions Counselor (NCAC or MAC).
- If certified by the DCB, you must be certified as a Certified Alcohol and Drug Counselor.
- For DCB contact information, see www.delawarecertificationboard.org.
- For NAADAC contact information, see www.naadac.org.
- If you are certified by an organization other than DCB or NAADAC, the organization must be acceptable to the Board. Arrange for the Board office to receive verification of your certification sent directly from the organization to the Board office. In addition, provide other documentation to help the Board evaluate the organization.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Additional Requirements for Applications by *Certification*

If you are applying by certification, you must submit documentation of your counseling education and post-Masters experience in substance abuse counseling in addition to the items listed in **Requirements for *All* Applications** above. **A resume will *not* be accepted in lieu of or in addition to the forms listed in this section.**

Chemical Dependency Professional
POST-MASTERS SUBSTANCE ABUSE COUNSELING EXPERIENCE REQUIREMENTS

The following definitions apply to the experience requirement:

- *Professional counseling experience* means hours spent providing chemical dependency counseling services in a substance abuse counseling setting, including face-to-face interaction with clients and other services directly related to treatment of clients.
- *Counseling experience* means a formal, systematic process that focuses on skill development and integration of knowledge related to addiction counseling and reflects the accumulation of hours spent providing substance abuse counseling services while under the supervision of an approved clinical supervisor.
- *Supervised counseling experience* means an approved clinical supervisor's oversight of a supervisee's application of chemical dependency counseling principles, methods or procedures to assist clients in achieving more effective personal and social adjustment.
- An *approved clinical supervisor* must be a licensed chemical dependency professional, licensed clinical social worker, licensed psychologist, licensed professional counselor of mental health or licensed physician specializing in chemical dependency treatment.

Applicants are required to have at least 3,200 hours of post-Masters substance abuse counseling experience:

- At least 1,600 of the 3,200 hours must be ***counseling experience*** under the supervision of one or more ***approved clinical supervisors***.
- At least 100 of the 1,600 hours of supervised counseling experience must be face-to-face consultation between you and your supervisor. These hours may take place in individual and/or in group settings, as follows:
  - The entire 100-hour requirement may be met by individual supervision, which means one-to-one, face-to-face meetings between you and your supervisor.
  - No more than 40 hours of the 100-hour requirement may be met by group supervision, which means face-to-face meetings between you, your supervisor and up to five other supervisees.

The experience requirements listed above are in 24 *Del. C*. §3044 of the license law and Section 4.1.2 of the Board's Rules and Regulations. Both are available at www.dpr.delaware.gov.

☐ Arrange for the Board office to receive an official transcript showing your Masters degree, sent *directly* from the college/university to the Board office.
- The transcript must show that you have 30 graduate semester hours in counseling or subjects closely related to counseling.
- If you have more than one graduate degree, arrange for the Board office to receive official transcripts for all of them.

☐ To verify the minimum 3200 hours of substance abuse counseling experience, arrange for the Board office to receive *Counseling Experience Verification* forms completed and signed by your administrative or clinical supervisor(s) or, if you were self-employed, completed and signed by a person whom you designate as an objective agent.
- The person completing the form must mail it *directly* to the Board office.
- The forms must clearly indicate the number of unsupervised ***substance abuse counseling experience*** hours.

☐ To verify the required minimum 1,600 hours of supervised counseling, arrange for the Board office to receive one or more *Supervision Reference* forms completed and signed by your approved clinical supervisor(s).
- The person completing the form must mail it *directly* to the Board office.
- The forms must clearly indicate the number of supervised ***substance abuse counseling*** hours.

Additional Requirements for Applications by *Reciprocity*

Whether or not documentation in addition to that listed in the **Requirements for *All* Applicants** section above is required depends on whether you have been licensed in good standing for five years in any of the other jurisdictions where you hold a *current* license.

- If you have been licensed in good standing for five years in *any* other jurisdiction where you now hold a current license, no further documentation is needed.
- If you have been licensed less than five years in *each* individual jurisdiction where you are currently licensed, submit copies of the other jurisdictions' licensing statute and rules and regulations for the Board to review. The Board will determine if any of the other jurisdiction's statute/rules and regulations are substantially similar to those of Delaware.

If you apply by reciprocity with less than five years of practice in any other jurisdiction and the Board later determines that none of the other jurisdictions' requirements are substantially similar to those of Delaware, you will be asked to provide the additional documentation of your counseling education and experience as listed in the **Requirements for Applications by *Certification*** section above. The Board will then consider you for licensure by certification.

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APPLICATION FOR CHEMICAL DEPENDENCY PROFESSIONAL LICENSURE

TYPE OF APPLICATION

1. Select the type of application you are filing (check one):

   ☐ Reciprocity – I hold a *current* Chemical Dependency Professional license in another jurisdiction (state, District of Columbia or U.S. territory).

   ☐ Certification – I do ***not*** hold a *current* license in another jurisdiction but I am currently certified by NAADAC as a National Certified Addictions Counselor (NCAC or MAC), by DCB Inc as a Certified Alcohol and Drug Counselor or by another national mental health specialty certifying organization.

IDENTIFYING AND CONTACT INFORMATION – *All* applicants complete this section.

2. Full Name: _____ _____ _____
   Last First Middle

3. Other Names Used: ☐ None _____ _____ _____
   (Include maiden, prior married, alternate spellings)

4. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

5. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

6. Mailing Address: _____

   _____ _____ _____
   City State Zip

7. Phone: _____ _____ Email: _____ ☐ None
   Home Work

NATIONAL CERTIFICATION – *All* applicants complete this section.

8. Do you hold current certification from the DCB Inc, NAADAC or other national mental health specialty?
   Yes ☐ No ☐ If yes, complete the following information about your certification(s):

CERTIFYING ORGANIZATION	CERTIFICATION NUMBER	DATE CERTIFIED	EXPIRATION DATE
DCB			
NAADAC			
Other: _____			

If you are certified by DCB Inc or NAADAC, arrange for the Board office to receive the appropriate *Certification* form sent *directly* from the organization. If you are certified by another national mental health specialty, arrange for the Board office to receive verification of your certification sent *directly* from the organization to the Board office.

LICENSURE HISTORY – *All* applicants complete this section.

9. Have you ever been denied licensure in any other jurisdiction? Yes ☐ No ☐ If yes, explain fully:

   _____

10. Have you ever held a license to practice as a mental health professional in any jurisdiction other than Delaware? Yes ☐ No ☐ If yes, enter the following information about *each* mental health license that you have *ever* held.

JURISDICTION	TYPE OF LICENSE HELD	LICENSE NUMBER	LICENSURE DATES	
			From	To

- **Arrange for the Board office to receive a verification of licensure from *each* jurisdiction where you have *ever* held a chemical dependency professional license.**
- **If you are applying by reciprocity but you have *not* held any of the *active* licenses listed above for *at least five years*, arrange for the Board office to receive a copy each jurisdiction's law and regulations to be compared to those of Delaware.**

GRADUATE EDUCATION – *All* applicants complete this section.

11. Have you earned a Master's or higher post-graduate degree(s) with at least 30 graduate semester hours in counseling or subjects closely related to counseling? Yes ☐ No ☐ If yes, enter this information about *all* ***graduate*** degrees you have received.

EDUCATIONAL INSTITUTION	GRADUATE DEGREE	DATE AWARDED	FIELD OF STUDY

If you are applying by certification, arrange for the Board office to receive an official transcript sent *directly* from *each* college/university listed to the Board office.

DISCLOSURES – *All* applicants complete this section.

12. Have you received any administrative penalties regarding your actions as a licensed, registered or certified mental health provider, including but not limited to fines, formal reprimands, license suspensions or revocation (except for license revocations for nonpayment of license renewal fees), probationary limitations, and/or have you entered into any "consent agreement" which contains conditions placed by a Board on your professional conduct, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such penalties.**

13. Are any disciplinary actions pending against you? Yes ☐ No ☐ **If yes, enclose a detailed explanation of any pending actions.**

14. Have you done any of the following grounds for discipline:
    - committed or knowingly cooperated in a fraud or material deception in order to acquire a license? Yes ☐ No ☐
    - impersonated another person holding a license? Yes ☐ No ☐
    - allowed another person to use your license? Yes ☐ No ☐
    - aided or abetted an unlicensed person to represent himself or herself as a licensee? Yes ☐ No ☐

    If yes to *any*, enclose a detailed explanation of the violations.

15. Do you currently excessively use or abuse drugs or have you done so in the past 3 years? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

16. Have you engaged in an act which involved consumer fraud or deception, restraint of competition, or price fixing? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

17. Do you have any impairment related to drugs or alcohol or a finding of mental incompetence by a physician that would limit your ability to act as a chemical dependency professional in a manner consistent with the safety of the public? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

18. Have you been penalized for any willful violation of the code of ethics adopted by the Board, the NAADAC code of ethics or other similar professional mental health counseling standard? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

19. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such violations,**

DUTY TO REPORT – *All* applicants complete this section.

20. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to report, in writing, within 30 days of becoming aware of information that you reasonably believe indicates that ***any healthcare provider*** including (but not limited to) any practitioner certified and registered to practice medicine in Delaware or licensed by the Board of Mental Health and Chemical Dependency Professionals
    - has engaged, or is engaging, in conduct that would constitute grounds of discipline under their licensing laws, or
    - may be unable to practice with reasonable skill and safety to the public by reason of mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol).

    I certify that I have read and understand 24 *Del. C*. §3018, 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report* to the Division of Professional Regulation. Yes ☐ No ☐

21. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

22. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to **self report** when your license to practice in another jurisdiction has been disciplined, surrendered, suspended or revoked.

    I certify that I have read and understand 24 *Del. C*. §3009 (a) (7) and that I understand my *duty to self report*. Yes ☐ No ☐

PROFESSIONAL COUNSELING EXPERIENCE – Only applicants *by certification* complete this section.

23. On the next page, list your post-Masters professional substance abuse counseling experience. Begin with your most recent experience and work backward. When listing your experience, remember…
    - ***All*** the experience you list should total at least 3200 hours.
    - At least 1,600 of the 3,200 hours must be ***counseling experience*** under the supervision of one or more ***approved clinical supervisors***.
    - At least 100 of the 1,600 hours of supervised counseling experience must be face-to-face consultation between you and your supervisor. These hours may take place in individual and/or in group settings, as follows:
        - o The entire 100-hour requirement may be met by individual supervision, which means one-to-one, face-to-face meetings between you and your supervisor.
        - o No more than 40 hours of the 100-hour requirement may be met by group supervision, which means face-to-face meetings between you, your supervisor and up to five other supervisees.
    - In TOTAL HOURS, calculate and enter how many hours of ***actual substance abuse counseling*** you provided during that period. Answers such as “40 hours/week” will ***not*** be accepted.

If you need more room, you may copy this page.

PERIOD FROM _____ TO _____
(Do not list to present)

1. Setting/Location Name: _____

2. Address: _____

_____ _____ _____
City State Zip

Business Phone: _____ Email: _____

3. Description of Setting/Location: ☐ Private/group practice ☐ Community mental health agency
☐ Elementary school ☐ Other: _____

4. Were you self-employed at this location/setting? Yes ☐ No ☐ If yes, ***business license*** number: _____

5. Your Job Position/Title: _____

6. Describe your job responsibilities and activities (use additional page if needed): _____

_____

_____

_____

7. Enter the following information about the person(s) who will verify your experience at this setting/location:

NAME AND RELATIONSHIP TO YOU	ADDRESS	PHONE/EMAIL
☐ Clinical Supervisor ☐ Administrative Supervisor ☐ Designated Agent		
☐ Clinical Supervisor ☐ Administrative Supervisor ☐ Designated Agent		
☐ Clinical Supervisor ☐ Administrative Supervisor ☐ Designated Agent		

TOTAL HOURS OF UNSUPERVISED EXPERIENCE _____
TOTAL HOURS OF EXPERIENCE UNDER SUPERVISION OF APPROVED CLINICAL SUPERVISOR _____
TOTAL HOURS OF UNSUPERVISED AND SUPERVISED EXPERIENCE _____

- **To verify the required 1,600 hours of supervised counseling experience, arrange for the Board office to receive *Supervision Reference* forms completed and signed by your clinical supervisor(s) and mailed *directly* to the Board office.**
- **To verify the remaining hours of the total 3,200 required hours, arrange for the Board office to also receive *Counseling Experience Verification* forms.**
- **See Instruction Sheet for information on who must complete and sign *Counseling Experience Verification* forms.**

To ensure consideration of your license application at the next Board meeting, the Board office must receive all of these items *no later than* 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not *complete* within 12 months of filing may be considered abandoned and discarded. When your application is *complete*, please allow 4-6 weeks to receive your license.

AFFIDAVIT

The undersigned applicant for licensure as a Chemical Dependency Professional, being sworn, deposes and affirms that he or she is the person who executed this application; that the statements contained on this application are true in every respect; that he or she has not suppressed or withheld information that might affect this application; that he or she will abide by the laws and the ethical standards of this profession; and that he or she has read and understands this statement.

The applicant authorizes all jurisdictions to release any and all information regarding his/her disciplinary history and current status to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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SUPERVISION REFERENCE

CHEMICAL DEPENDENCY PROFESSIONALS

INSTRUCTIONS

The purpose of this form is to verify the ***hours of substance abuse counseling*** that an applicant has provided while under the ***supervision*** of an ***approved clinical supervisor***. This form is not required for applicants applying by reciprocity.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application.*** The clinical supervisor must complete the entire form, sign it and mail it *directly* to the Board office at the address above. Forms not received *directly* from the supervisor will not be accepted.

The applicant is not to complete any portion of this form!

The following definitions apply to the experience requirement:

- Professional counseling experience means hours spent providing chemical dependency counseling services in a substance abuse counseling setting, including face-to-face interaction with clients and other services directly related to treatment of clients.
- Counseling experience means a formal, systematic process that focuses on skill development and integration of knowledge related to addiction counseling and reflects the accumulation of hours spent providing substance abuse counseling services while under the supervision of an approved clinical supervisor.
- Supervised counseling experience means an approved clinical supervisor's oversight of a supervisee's application of chemical dependency counseling principles, methods or procedures to assist clients in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed chemical dependency professional, licensed clinical social worker, licensed psychologist, licensed professional counselor of mental health or licensed physician specializing in chemical dependency treatment.

Applicants are required to have at least 3200 hours of post-Masters substance abuse counseling experience. Of the 3200 hours, at least 1600 hours must be ***counseling experience*** under the supervision of one or more ***approved clinical supervisors***. In addition, at least 100 of the 1600 hours of supervised counseling experience must be face-to-face consultation between the applicant and his/her approved clinical supervisors. These hours may take place in individual and/or in group settings, as follows:

- The entire 100-hour requirement may be met by individual supervision, which means one-to-one, face-to-face meetings between the applicant and supervisor.
- No more than 40 hours of the 100-hour requirement may be met by group supervision, which means face-to-face meetings between the applicant, the supervisor and up to five other supervisees.

The experience requirements are in 24 *Del. C*. §3044 of the license law and Section 4.1.2 of the Board's Rules and Regulations. Both are available at www.dpr.delaware.gov.

INFORMATION ABOUT CLINICAL SUPERVISOR

1. Applicant Name: _____ _____ _____
   Last First Middle

2. Direct Supervisor Name: _____ _____ _____
   Last First Middle

   Title: _____

3. Practice Address: _____

_____ _____ _____
City State Zip

4. Phone: _____ Email: _____

5. Provide the following information about the professional licenses you held at the time you supervised the applicant.

✓	LICENSES HELD (check all that apply)	JURISDICTION	LICENSE #	ISSUE DATE
☐	Chemical Dependency Professional			
☐	Professional Counselor of Mental Health			
☐	Clinical Social Worker			
☐	Physician *(specializing in chemical dependency treatment)*			
☐	Clinical Psychologist			

VERIFICATION OF EXPERIENCE HOURS

6. Did you provide the applicant with ***supervised*** counseling experience, as defined in Instructions, to this applicant? Yes ☐ No ☐ If no, you may have received this form in error. If you can verify the applicant's *unsupervised* counseling experience, the correct form is the *Counseling Experience Verification Form.* If you know who provided the applicant with face-to-face supervision, enter the following information and then skip to the **Signature**:

   Name of Supervisor:_____

   Setting/Location Where Supervision Occurred: _____

7. Enter the following information about the setting/location where you supervised the applicant named above:

   Setting/Location Name: _____

   Address: _____

   Description (e.g., private practice, community mental health agency, etc.): _____

8. Enter the dates of that you supervised the applicant:

   From _____ To _____
   Month/Year Month/Year

9. During this period, how many total hours of substance abuse counseling did the applicant provide while under your supervision? _____

Calculate and enter a total number of hours. Answers such as "40 hours/week" will not be accepted.

10. During this period, how many total hours of face-to-face, individual (one-on-one) supervision, as defined in Instructions, did you provide to the applicant? _____

11. During this period, how many total hours of face-to-face, group supervision, as defined in Instructions, did you provide to the applicant? _____

CERTIFICATION

I certify that I personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge and belief and that this applicant competently and satisfactorily performed his/her counseling duties.

Clinical Supervisor Signature: _____ Date: _____

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COUNSELING EXPERIENCE VERIFICATION FORM

CHEMICAL DEPENDENCY PROFESSIONALS

INSTRUCTIONS

The purpose of this form is to verify the ***hours of substance abuse counseling*** that an applicant has provided while ***not*** under the ***supervision*** of an ***approved clinical supervisor***. Hours of counseling provided while under the supervision of an approved clinical supervisor are verified on the *Supervision Reference* form. Do not enter such supervised counseling hours on *this form.* This form is not required for applicants applying by reciprocity.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application*.** If the applicant was an employee, the applicant's clinical or administrative supervisor must complete the entire form and sign it. If the applicant was self-employed, the person whom the applicant designated as an objective agent must complete the entire form and sign it. The form should then be mailed *directly* to the Board office at the address above. The Board office will not accept forms that are not received *directly* from the supervisor or agent.

The applicant is not to complete any portion of this form!

The following definitions apply to the experience requirement:

- Professional counseling experience means hours spent providing chemical dependency counseling services in a substance abuse counseling setting, including face-to-face interaction with clients and other services directly related to treatment of clients.
- Counseling experience means a formal, systematic process that focuses on skill development and integration of knowledge related to addiction counseling and reflects the accumulation of hours spent providing substance abuse counseling services while under the supervision of an approved clinical supervisor.
- Supervised counseling experience means an approved clinical supervisor's oversight of a supervisee's application of chemical dependency counseling principles, methods or procedures to assist clients in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed chemical dependency professional, licensed clinical social worker, licensed psychologist, licensed professional counselor of mental health or licensed physician specializing in chemical dependency treatment.

Applicants are required to have at least 3200 hours of post-Masters substance abuse counseling experience. Of the 3200 hours, at least 1600 hours must be ***counseling experience*** under the supervision of one or more ***approved clinical supervisors***. In addition, at least 100 of the 1600 hours of supervised counseling experience must be face-to-face consultation between the applicant and his/her approved clinical supervisors. These hours may take place in individual and/or in group settings, as follows:

- The entire 100-hour requirement may be met by individual supervision, which means one-to-one, face-to-face meetings between the applicant and supervisor.
- No more than 40 hours of the 100-hour requirement may be met by group supervision, which means face-to-face meetings between the applicant, the supervisor and up to five other supervisees.

The experience requirements are in 24 *Del. C*. §3044 of the license law and Section 4.1.2 of the Board's Rules and Regulations. Both are available at www.dpr.delaware.gov.

INFORMATION ABOUT SUPERVISOR OR AGENT

1. Applicant Name: _____ _____ _____
   Last First Middle

2. Supervisor/Agent Name: _____ _____ _____
   Last First Middle

3. Title: _____

4. Phone: _____ Email: _____

5. Check your association to the applicant:

   ☐ Clinical Supervisor – skip to the **VERIFICATION OF COUNSELING HOURS** section.

   ☐ Administrative Supervisor – skip to the **VERIFICATION OF COUNSELING HOURS** section.

   ☐ Objective Agent – continue with the next question.

6. Do you have personal knowledge of the extent of the applicant's professional practice while he or she was self-employed? Yes ☐ No ☐ If yes, explain your professional relationship to the applicant: _____

   _____

7. Are you related to the applicant as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law? Yes ☐ No ☐ If yes, specify relationship: _____

VERIFICATION OF COUNSELING HOURS

8. Enter the following information about the setting/location where the applicant provided substance abuse counseling:

   Name: _____

   Address: _____

   _____ _____ _____
   City State Zip

   Description: ☐ Alcohol and drug treatment center ☐ Outpatient or detox ☐ Residential ☐ Methadone clinic
   ☐ Partial hospital program ☐ Hospital setting ☐ School setting
   ☐ Other: _____

9. Enter the dates that the applicant provided substance abuse counseling at this setting/location:

   From _____ To _____
   Month/Year Month/Year

   Calculate and enter a total number of hours in the questions below. Answers such as "40 hours/week" will not be accepted.

10. During this period, how many ***TOTAL*** hours of ***unsupervised*** substance abuse counseling did the applicant provide in this setting/location? _____

CERTIFICATION

I certify that I personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge and belief and that this applicant competently and satisfactorily performed his/her counseling duties.

Supervisor/Agent Signature: _____ Date: _____

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DELAWARE CERTIFICATION BOARD, INC., CERTIFICATION FORM

INSTRUCTIONS

The applicant below has applied for Delaware licensure as a chemical dependency professional. This form elicits information about the applicant's certification issued by the Delaware Certification Board, Inc. (DBC, Inc.)

- The applicant completes the **APPLICANT INFORMATION** section and sends the form to the certifying organization. Contact information may be found at www.delawarecertificationboard.org.
- An official of DCB, Inc. completes the **CERTIFICATION INFORMATION** section, signs the form and mails it *directly* to the Board office at the address above.

INFORMATION ABOUT APPLICANT

1. Full Name: _____ _____ _____
   Last First Middle

2. Mailing Address: _____

   _____ _____ _____
   City State Zip

3. Enter the following information about your certification:

   Certified as: _____ Certification No. _____

   Date Certified: _____ Expiration Date: _____

I authorize the certifying agency named above to release information regarding my certification to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Applicant Signature: _____ Date:_____

CERTIFICATION INFORMATION

1. Is the applicant currently certified as a Certified Alcohol and Drug Counselor? Yes ☐ No ☐

2. Is the applicant currently in good standing? Yes ☐ No ☐

3. If the answer to either of the above is "no," please explain fully _____

   _____

   _____

   _____

Signature of DCB Inc. Official: _____ Date: _____

Printed Name of Official: _____ Title: _____

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

NAADAC CERTIFICATION FORM

INSTRUCTIONS

The applicant below has applied for Delaware licensure as a chemical dependency professional. This form elicits information about the applicant's certification issued by the NAADAC.

- The applicant completes the **APPLICANT INFORMATION** section and sends the form to the certifying organization. Contact information may be found at www.naadac.org.
- An official of NAADAC completes the **CERTIFICATION INFORMATION** section, signs the form and mails it *directly* to the Board office at the address above.

INFORMATION ABOUT APPLICANT

1. Full Name: _____ _____ _____
   Last First Middle

2. Mailing Address: _____

   _____ _____ _____
   City State Zip

3. Enter the following information about your certification:

   Certified as: _____ Certification No. _____

   Date Certified: _____ Expiration Date: _____

I authorize the certifying agency named above to release information regarding my certification to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Applicant Signature: _____ Date:_____

CERTIFICATION INFORMATION

1. Is the applicant currently certified as a NCAC I, NCAC II or MAC? Yes ☐ No ☐

2. Is the applicant currently in good standing? Yes ☐ No ☐

3. If the answer to either of the above is "no," please explain fully _____

   _____

   _____

   _____

Signature of NAADAC Official: _____ Date: _____

Printed Name of Official: _____ Title: _____

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VERIFICATION OF LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice as a mental health practitioner. Before sending this form to the jurisdiction, it is advisable to find out if the jurisdiction requires a fee to provide a license verification. You may duplicate this form.

This section to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ Date of Birth:_____ Other Name(s) Used: _____ Jurisdiction Where Licensed: _____ License/Registration Number(s) in Jurisdiction Named Above: _____ **I am applying for Delaware licensure as a:** ☐ **Professional Counselor of Mental Health** ☐ **Associate Counselor of Mental Health** ☐ **Chemical Dependency Professional** ☐ **Marriage and Family Therapist** ☐ **Associate Marriage and Family Therapist** **Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Mental Health and Chemical Dependency Professionals.** **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority.	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of: _____ as a (type of license) _____ Registration/License Number: _____ Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____ Has the licensee ever been subject to any disciplinary action or had his/her license revoked or suspended? Yes ☐ No ☐ **If yes, please enclose a certified copy of the board's final order with this license verification.** Are any disciplinary proceedings or unresolved complaints pending against the licensee? Yes ☐ No ☐
AFFIX OFFICIAL SEAL HERE	***I certify that the statements contained herein are true and correct.*** Printed Name of Official: _____ Signature of Official: _____ Date: _____ Title:_____ Phone: _____ Fax: _____ Email:_____

Return completed, signed and sealed form *directly* to the Board office at the address above.

Revised 9/2017

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

Revised 9/2017

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 9/2017